STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145339	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Elmhurst, The	127 West Diversey Elmhurst, IL 60126

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44387 Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse. This failure affected 2 of 5 residents (R1 and R2) reviewed for physical abuse and resulted in R3 hitting R1 and R2 on the head. The findings include: The facility's Abuse Investigation Report submitted to Illinois Department of Public Health on 11/18/24 states, On 11/18/24 at approximately 18:15 (6:15pm) [R3] allegedly engaged in physical altercation with residents [R1] and [R2] after [R3] got a hold of a decorative flagstick and started hitting both residents with a stick. All residents have been separated immediately. No injury was noted to [R1] at this time. Noted bleeding on [R2's] head at this time . [R1] and [R2] will be sent out to ER for further evaluation . Police . notified . On 12/19/24 at 10:14 AM, R3 was sitting in a chair by nurse's station. R3 said, he may have gotten into a situation with another resident, and he may have possibly hit another resident, or another resident may have possibly hit him. R3's Face Sheet shows the following diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, depression, dementia, and PTSD. R3's MDS (Minimum Data Set) of 11/18/24 shows that his cognition is severely impaired. R3's Progress notes of 11/18/24 at 6:15 PM showed resident hit another resident on the head with a flag stick in front of nurse's station and another resident with headphones that was on his head in front of room. Resident seemed agitated. On 12/19/24 at 10:12 AM, R2 was resting in bed in his room. R2 said he does not recall being hit by another resident. R2's Face Sheet shows the following diagnoses of and contusion of scalp, epilepsy, and history of falling. R2's MDS of 12/11/24 shows that his cognition is severely impaired. R2's Progress notes of 11/18/24 at 8:55 PM, states, resident was hit on the head with a headphone by another resident, roommate Resident slid to the floor in the course of defending himself. Resident was noted bleeding from left side of head . small skin tear measuring 0.3 cm was observed . recommendation of primary clinician: ordered to send to hospital for further evaluation. R2's After Visit Summary record of 11/18/24 shows that he was assessed for head injury. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145339	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Elmhurst, The	127 West Diversey Elmhurst, IL 60126

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 was discharged from facility on 12/8/24. R1's Face Sheet shows the following diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dementia, anxiety disorder, post-traumatic stress disorder (PTSD) and mild cognitive impairment. R1's (MDS) of 10/14/24 shows that his cognition is intact. R1's Progress Notes of 11/18/24 at 7:51 PM states, resident got hit on the head with American flag stick by another resident. No injury noted at this time . recommendation of primary clinician: ordered to send resident to ER (emergency room) for further evaluation. R1's After Visit Summary record of 11/18/24 shows that he was assessed for physical assault. On 12/19/24 at 1:07 PM, V9 (Licensed Practical Nurse/LPN) said on the day of the incident, she heard a noise down the hallway; when she went down to check, she saw R3 hitting R1 with a small American Flag stick on the head. V9 said that R1 was upset, and he was trying to protect his head. V9 said she separated the residents and called for staff assistance. V9 said that a CNA (Certified Nurse Aide) took R3 to his room. V9 said shortly after the incident, she heard another noise down the hallway. V9 said she saw R3 fighting R2 for his headphones right outside their room. V9 said she did not see R3 hit R2, and they separated R2 and R3. On 12/20/24 at 8:34 AM, V8 (LPN) said while she was at the nurse's station, she heard a commotion down the hall. V8 said she ran down, and saw R1 and R3 in the hallway, was told by staff that R3 hit R1 on the head with an American flag stick. V8 said both residents were separated, R3 was escorted to his room. V8 said a few minutes later, there was another commotion right outside of R3's room. R3 was seen hitting R2 on the head with headphones. V8 said both residents were separated again. On 12/19/24 at 1:20 PM, V10 (CNA) said on the day of the incident, while she was at the nurse's station, she heard a commotion between R1 and R3. V10 said both residents were separated, and she took R3 to his room. V10 said while she was reporting the incident to the nurse, she heard another commotion and saw R3 and R2 down the hall. R2 was holding his head. V10 said she did not see R3 hit R2. V10 said R2 told her that R3 was trying to take his headphones off his head. V10 said the incident happened right outside of R2 and R3's room; they were roommates. V10 said that both residents were separated. On 12/19/24 at 2:07 PM, V3 (Interim Director of Nursing/DON) said it was reported to him that R3 hit R1 and R2. V3 said that R2 had slight bleeding to his head and R1 did not have any injury. V3 said both R1 and R2 were sent to the hospital for further evaluation. The facility's Abuse and Neglect policy (revised 7/12/24) defined Abuse as willful infliction of mistreatment, injury, .intimidation, or punishment. Abuse assumes intent to harm, but inadvertent or careless behavior done deliberately that results in harm may be considered abuse . The policy continued to show that the facility will provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment.